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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979
NO. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services the State of New Jersey, PETITIONERS

v.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey, RESPONDENT

AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS AND THE STATES OF OHIO, NEW HAMPSHIRE, AND WYOMING IN SUPPORT OF THE STATE OF NEW JERSEY'S PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

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INTEREST OF THE AMICI

The Commonwealth of Massachusetts and the states of Ohio, New Hampshire, and Wyoming (the amici states) file this amicus brief in support of the State of New Jersey's petition for a writ of certiorari to the Supreme Court of New Jersey in the case of Monmouth Medical

Center v. State of New Jersey, 80 N.J. 299, 403 A.2d 487 (1979) (Monmouth). The amici states seek to express their concern that the Court not permit the structure and operation of the state-federal Medicaid program, in which they participate along with New Jersey, to be drastically and unwisely altered by judicial decision unsupported by statutory requirement. In particular, they seek to place the Supreme Court of New Jersey's decision in Monmouth in the context of other similar decisions of the state and federal courts and identify the shared elements of erroneous reasoning which have led to the imposition of unanticipated burdens and restrictions upon the participating states. As those who must bear these burdens and adjust to these restrictions, the amici states are perhaps uniquely qualified to convey these concerns to the Court.

SUMMARY OF ARGUMENT

In the first portion of their argument, the amici states collected and analyze recent cases under title XIX which, like Monmouth, impose considerable financial and administrative burdens upon the states. The amici states argue that these decisions, as does Monmouth, lack support in the statute. The amici states also argue that

these decisions, by disregarding established approaches to statutory interpretation and deferring insufficiently to state and agency discretion, severely disrupt the relationships between the states and the federal government. Finally, the amici states observe that Monmouth and cases similar to it exhibit a strong end-result orientation and that this orientation, however desirable as a matter of broad social policy, is an improper one for the federal and state courts to employ in deciding cases under title XIX.

The amici states dedicate the second portion of their argument to a review of title XIX's controversial "necessary medical services" language. The meaning of this phrase is critical to the Supreme Court of New Jersey's decision in Monmouth and the decisions of the lower federal courts in similar cases. What Congress meant by the phrase is also generally misunderstood. To demonstrate the fundamental nature of this misunderstanding and provide the Court with a basis for perceiving the phrase's proper interpretation, the amici states present a careful analysis of title XIX's legislative history. This analysis demonstrates that Congress did not use the phrase "necessary medical services" as a substitute for the term "medically necessary" services

and that title XIX does not require the states, as the court in Monmouth held, to reimburse health care providers for the costs of "medically necessary" health care.

ARGUMENT

I. The Nature Of The Problem

Must a state provide reimbursement for the costs of a particular "medically necessary" health care service under its Medicaid program? If so, why? These two questions embody the essence of a large and various class of cases with which the federal and state courts have been required to deal since this Court's decision in Beal v. Doe, 432 U.S. 438 (1977). In Beal, this Court held that title XIX of the Social Security Act does not impose upon states which choose to participate in the cooperative federal-state program of medical assistance which it authorizes an obligation to reimburse health care providers for the costs of "elective" health care services not included in a state's approved plan for medical assistance. In reaching this conclusion, the Court, as it had in earlier A.F.D.C. cases,[1/] stressed that the ques-

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1/ E.g., Burns v. Alcala, 420 U.S. 575 (1975).

tion involved was one of statutory interpretation and set forth an analytical model which, one might have supposed, lower courts would recognize as the one to use when called upon to resolve similar controversies. Unfortunately, with a few encouraging exceptions, the federal and state courts have failed to adopt this Court's approach to the interpretation of title XIX's provisions and, instead, reached decisions imposing requirements upon the states which lack support in the statute's provisions and any resemblance to the analytical methodology used in Beal. More than the results in individual cases, it is the lower courts' failure to understand and accept the Beal methodology[2/] which has led to the significant adverse judicial alterations of the

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[2/] While Beal's status as a model of analysis is well-deserved, it does contain an unfortunate element of commentary which is largely responsible for the present controversy over "medically necessary" services. The troublesome dictum appears near the end of the Court's analysis of the statutory issue: "Although serious statutory questions might be presented if a state medicaid

national Medicaid program[3/] of which Monmouth is a glaring instance. A few examples of the reasoning pro-

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[2/] continued

plan excluded medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary — though perhaps desirable — medical services... [emphasis supplied and in the original]."

This dictum has led many lower courts to assume an admittedly serious question has an even more serious answer, i.e., that title XIX does require states to pay for "medically necessary" services. Recognizing the limitations of this brief in support of New Jersey's petition for certiorari, the amici states argue in an abbreviated form in section two that this conclusion is a most serious mistake. Should the Court have a similar perception, the amici states are prepared to detail their view in an amicus brief on the merits.

[3/] A compendium of these cases appears as Appendix A to this brief.

cesses which the lower courts have used instead of the approach embodied in Beal may help to make these observations concrete, and the opinion of the Supreme Court of New Jersey in this case provides a logicial starting point for this survey.

The Supreme Court of New Jersey based its holding in Monmouth upon a determination that the state's restrictions on hospital reimbursement for services rendered to patients who might equally well be cared for in a less expensive facility were a bed available, e.g., a nursing home, are unreasonable and therefore invalid under title XIX. 80 N. J. 299, 309-11, 403 A.2d 487, 492-93. After discussing various policy considerations, the court below reached its conclusion in a single sentence: "Nevertheless, in order not to transcend the Federal Act, the Division must exercise discretion so as to allow reimbursement where medically necessary care has been rendered to an unavoidably retained patient." Id.; 403 A.2d at 493. This conclusion, unadorned by citation to statutory or decisional law and uninformed, apparently, by a review of the Social Security Act's legis-

lative history,[4] at once imposes upon the State of New Jersey and the United States an additional financial burden which New Jersey estimates may amount to as much as 37 million dollars.[5]

Unlike Beal, where this Court observed that title XIX "makes no reference to abortions, or, for that matter, to any other particular medical procedure...," that the statute "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act [footnote omitted, emphasis supplied]," and therefore concluded that title XIX does not require the states to provide

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4/ See pages 26-41, below.

5/ This figure represents the State of New Jersey's estimate of its additional expenses, nineteen million dollars, and the United States's equal additional contribution. See Petition for Certiorari at 20.

reimbursement for the costs of elective abortions, the court below was content to rely upon broad policy arguments to justify its conclusion that New Jersey is required to reimburse hospitals for the costs of acute care services delivered to patients who do not need them. See, e.g., 80 N.J. at 310-13, 403 A.2d at 492-94. The fact that the court summarizes its conclusion in terms of "reasonableness" does not alter its essential nature as nothing more than a substituted judgment, on public policy grounds, of issues and considerations which the state and federal administrative agencies charged with responsibility for administering the Medicaid program in New Jersey have assessed differently.[6/]

6/ Although the court says that its considers the state's rule "unreasonable," its argument demonstrates at most that reasonable minds may disagree. Such disagreements are not equivalent to the prohibition of "irrationality" which title XIX, under Beal, imposes upon the states.

The transsexual cases, in particular Rush v. Parham, 440 F. Supp. 383 (N.D.Ga. 1977), app. pending sub nom. Rush v. Poythress, No. 77-2743 (5th Cir.), present even more disturbing examples of the lower federal courts' disregard of the the proper and established approach to the interpretation of the Social Security Act.[7/] The issue in transsexual cases, speaking generally, is whether state plans for medical assistance under title XIX must reimburse hospitals and surgeons for the costs of providing sex change operations to eligible Medicaid recipients. In their strongest formulation, these cases present a claim that, although either explicitly or inferentially excluded from coverage under a particular

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7/ While it is true that Rush was decided several months after Beal and, indeed, relies heavily upon Beal's dictum, it might be unfair to hold the district court to a full appreciation of a virtually contemporaneous decision. However, Beal's methodology has a undeniably venerable lineage. E.g., Burns v. Alcala 420 U.S. 575 (1975); King v. Smith, 392 U.S. 309 (1968).

state plan, a state must provide reimbursement to providers of transsexual surgery services because such services are "medically necessary." E.g., Rush v. Parham, supra, at 389. In Parham, the district court reached its determination that "medically necessary" services "are the irreducible minimum coverage which states must provide..." on the basis of four remote and inferentially weak premises: first, this Court's dictum in Beal; second, the authorization of appropriations language in §1396; third, a definition of the phrase "medically needy"; and, fourth, a reference in regulations to acceptable bases for limiting the "scope, amount, and duration of benefits...." The significant aspect of this approach to decision making under title XIX is that it represents a precise inversion of the Beal methodology. That is, although lacking any concrete statutory basis for its conclusion that states must provide reimbursement for all "medically necessary" services, the court inferred the requirement and imposed it upon the State of Georgia. Surely, as in Beal, the result should have been exactly the opposite: if the statute does not explicitly require a state to provide reimbursement, the federal courts should not

do so. See Quern v. Mandley, U.S. , 98 S. Ct. 2068, 2077-78 (1978) (Stewart, J.)("But Congress' choice of precise language in this complex statute cannot be glossed over with such generalities..."); Burns v. Alcala, 420 U.S. 575, 577-80 (1975) (Powell, J.). At the very least, weak inferences of legislative intent, unsupported by substantial extrinsic evidence, should not be the basis for broad conclusions which fundamentally alter the structure and operation of a national welfare program.[8/]

Appreciation of another line of cases, symptomatic of the same methodological problems but occurring in a

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[8/] There is no doubt that imposition of a "medically necessary" requirement would work such changes. For example, it is well known that, ever since title XIX's inception, HEW has approved state plans for medical assistance which have excluded whole categories of services or limited their amount, scope, and duration in significant ways. See 2 CCH Medicare and Medicaid Guide, ¶¶ 15,501-15,660 (providing tables by state of approved state plan program components). Under cases such as Rush, HEW's action would be set aside if the excluded or limited services are considered "medically necessary."

constitutional context, begins with the Third Circuit's decision in Klein v. Califano, 586 F.2d. 250, an en banc decision affirming the District of New Jersey's determination in Klein v. Mathews, 430 F. Supp. 1005 (D.N.J. 1977). Klein, and others which have followed it,[9/] are cases involving claims that title XIX requires participating states and HEW to provide reimbursement pending notice and hearing to nursing homes which do not meet statutory standards because to deny reimbursement would be tantamount to depriving Medicaid recipients of their constitutionally protected expectation

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9/ E.g., Town Court Nursing Center, Inc. v. Beal, 586 F.2d 280 (3rd Cir. 1978), cert. granted sub nom. O'Bannon v. Town Court Nursing Center, Inc. 47 U.S.L.W. 3683 (April 6, 1979); Bracco v. Lackner, 462 F. Supp. 436 (N.D.Calif. 1978) (preliminary injunction); Newfield House, Inc. v. Commonwealth of Massachusetts, Civil Action No. 76-3742-G (complaint filed September 30, 1976) (pending on motions to dismiss and for partial summary judgment).

"to continued residency at the home of one's choice absent specific cause for transfer..." without due process. Klein, supra, at 258. In these cases, the lower federal courts have once again been willing to infer broad and burdensome requirements on the basis of immaterial or, at best, tangentially related statutory provisions. Not surprisingly, their reasoning is disjointed and unconvincing.[10/] The approach is nonetheless infectious, and,

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10/ Chief Judge Seitz's dissent in Town Court Nursing Center, Inc. v. Beal, supra, observes how unsatisfactory the Third Circuit's analyses in Klein and Town Court are:

> The majority finds that continued residence in the nursing home of one's choice absent specific cause for transfer is an underlying substantive interest created by three Mediciad provisions. Under the first, 42 U.S.C. §1396a(a)(23), a Medicaid recipient may obtain medical care "from any institution...qualified to perform the service or services required." Clearly, what the majority characterizes as a recipient's right to obtain medical care from a "freely

unless this Court administers an effective cure,

10/ continued

selected provider is limited to a choice among institutions which have been determined by the Secretary to be "qualified." Next, the majority's reliance on 45 C.F.R. § 205.10(a)(5), ensuring a notice and hearing to a recipient whose benefits are suspended, reduced, discontinued, or terminated, is obviously misplaced. As the majority itself notes, the decertification of these facilities did not reduce or suspend the residents' rights to continued benefits.

Finally, the majority relies upon 45 C.F.R. § 249.12(a)(1)(ii)(B)(4), which establishes as one requirement for an institution's certification that each resident admitted to that institution be "transferred or discharged only for medical reasons or for his welfare or

may reach epidemic proportions.11/

10/ continued

that of other patients, or for nonpayment for his stay." The majority reads this provision as a limitation on the Secretary's power to interrupt a recipient's residence at a particular institution. Clearly, however, this provision is a standard of conduct imposed by the Secretary upon the provider. Violation of this standard is one of the many grounds for decertifying the offending institution. See 45 C.F.R. §§ 249.33(a)(2), 249.10(b)(15). The provision creates no "substantive interest" in the residents vis-a-vis the Secretary. Town Court at 295-96.

11/ E.g., Bracco v. Lackner, 462 F. Supp. 436, 450, 452 (N.D.Cal. 1978) (preliminary injunction). Acceptance by such an important district demonstrates the appeal of the result in Klein and the uphill fight states must wage in light of the Third Circuit's ipse dixit approach to the interpretation of title XIX.

Mention of one final set of cases completes the survey. Following this Court's decision in Beal, litigation has developed across the country challenging state and federal restrictions on the reimbursement of "medically necessary" surgical services provided in connection with the performance of abortions. Currently, although the majority of district courts which have considered the question have held such restrictions impermissible under title XIX, two Courts of Appeals, those for the First and Seventh Circuits, have found persuasive the states' arguments that title XIX does not require reimbursement of all "medically necessary" services. Preterm v. Dukakis, 591 F.2d 121, 124-25 (1st Cir. 1979); Zbaraz v. Quern, 596 F.2d (7th Cir. 1979). However, while avoiding the precise error which the Supreme Court of New Jersey in Monmouth and the district court in Rush v. Parham, supra, commit, the First and Seventh Circuits, still content to skim the surface in their analyses of title XIX's requirements, held that it is " 'unreasonable' and 'wholly [in] consistent with the objectives of the Act,' 42 U.S.C. § 1396a(a)(17), for a state to provide abortion services and then, with limited exceptions for victims of rape and incest, deny it to all those who will not die without it."

Preterm v. Dukakis, supra at 126; accord, Zbaraz v. Quern, supra at 199. Why this is so, and particularly why it is so as a matter for which the abstract intellectual reasoning of a court is an acceptable substitute for deferential analysis of Congressional intent and HEW administrative action, the Courts of Appeals do not say.[12/] Indeed, they apparently feel no compulsion to do more than express their incredulity. See, e.g., Preterm at 126. But, of course, Beal establishes that the views of the Congress and HEW, not those of a federal court, are the standard against which courts should judge the conformity of state plans for medical assistance with the

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12/ That Congress did not intend the provisions of § 1396a(a)(17) to provide the basis for the federal courts' substituting their judgments of rational approaches to providing medical assistance for the decisions of state agencies and HEW is suggested in section two. Full argument on this point is deferred to briefing on the merits.

requirements of title XIX. Preterm and Zbaraz, as do Monmouth, Parham, and Klein, simply ignore the Beal methodology.

It is hard to resist observing at the end of this survey that the cases just discussed exhibit a strong end-result orientation. Judicial concern with results is not itself controversial, for in many cases, particularly those involving private litigants, it is the result which counts. But public law cases such as those just surveyed present a different problem. This type of litigation is an aspect of the process of government, and the process itself is therefore often more important than its results. Without denying the importance of society's caring responsibly for its aged and infirm and others too poor to obtain necessary health care services, the amici states submit that cases like Monmouth, Parham, Klein, and Preterm are objectionable primarily because their inadequate decision making methodology leads to the development of rules of law which, as the following discussion demonstrates, are contrary to those the Congress has formulated.

II. Title XIX Does Not Require Participating States To Provide Reimbursement For The Costs Of Any Particular "Medically Necessary" Service.

A. Introduction

Proper interpretation of the Social Security Act depends upon careful observation of its architecture. Although Congress has amended the statute often and substantially since its passage in 1935, its basic structure has exhibited remarkable endurance. Title XIX of the Act, codified as Chapter XII, subchapter XIX §§ 1396a - 1396k of the United States Code, follows closely the now classic style of the Act's draftsmen: Section 1901 (codified as 42 U.S.C. § 1396 (1976)) constitutes an appropriations authorization and embodies a subsidiary statement of purpose; section 1902 (codified as 42 U.S.C. § 1396a (1976)) establishes state plan requirements and directs the Secretary of Health, Education, and Welfare to approve plans which meet these requirements; section 1903 (codified as 43 U.S.C. § 1396b (1976)) requires the Secretary to reimburse states for certain portions of their expenditures "as medical assistance"; section 1904

(codified as 42 U.S.C. § 1396c (1976)) authorizes the Secretary of HEW to suspend payments after notice and hearing (the so-called "conformity hearing") upon a determination that a state has affected unlawful modifications in its state plan or has failed to administer it in substantial compliance with the state plan requirements contained in § 1902; section 1905 (codified as 42 U.S.C. § 1396d (1976)) provides definitions of selected terms, including and of particular importance for present purposes, "medical assistance"; and the remaining sections deal with miscellaneous matters, including criminal penalties for fraudulent claims, the certification of skilled nursing home facilities, and similar specific aspects of the Medicaid program.[13/]

Section 1901 provides, as it did when originally enacted in 1965, that:

> For the purpose of enabling each State as far

13/ A common short-hand way of referring to the major or original sections of the Act when one is concerned with their function regardless of the programmatic title in which they appear is by their last

> as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled[14/] individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for

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13/ continued

two digits (the first digit merely identifies the title). Thus, whatever the title, §§ 102, 402, etc. (the state plan requirements sections) are referred to as the "02" sections; §§ 103, 403, etc. (the payments to the states sections) as the "03" sections; and §§ 104, 404, etc. (the conformity hearing sections) as the "04" sections. The amici states also use this method of reference occasionally in this portion of their brief.

14/ 87 Stat. 960 substituted the term "disabled" for the phrase "permanently and totally disabled."

> independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

Four features of this section merit close attention. First, it is primarily an appropriations authorization and subsidiary statement of purpose section. Second, the section in terms imposes no substantive requirements upon the states. Rather, in its only sentence which can fairly be considered prescriptive, it simply restricts the use of the funds it authorizes to be appropriated each fiscal year to the making of payments to those states which have submitted "plans for medical assistance" to the Secretary of HEW and obtained the requisite approval of them. Third, as do the cognate sections of its predecessors and successors,[15/] the sectión begins with a

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15/ E.g., titles I and XX.

statement of purpose which announces Congress's intention as being to "[enable] each State, as far as practicable under the conditions in such state, to furnish...[emphasis supplied]" a certain type of public assistance ("medical assistance") to certain persons. Recognition of the financial limitations of state governments is clearly this language's purpose. Fourth and perhaps most importantly, the section never uses the phrase "medically necessary." Congress's omission of any reference to this concept in the design and construction of this section is, as the amici states argue later, quite intentional, and judicial attempts to conflate the phrase "necessary medical services" with the term "medically necessary" not only lack textual support but also do violence to the statute's architecture.

Section 1901 has two—and only two—functions to perform as a component of title XIX, and Congress designed it to perform these functions in concert with three other sections: 1902, 1903, and 1905. The first function is to operate as a standing authorization for appropriations. It performs this function in conjunction with §1903 which requires the Secretary to pay each state with an approved plan from appropriated funds "an amount equal to the Federal medical assistance percentage

(as defined in section 1905(b), subject to subsections (g), (e), and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan. . . ."

The second function is to limit the use of appropriated funds to the reimbursement of only those state expenditures incurred as "medical assistance provided to eligible persons." Since "medical assistance" is a defined term, see §1905(a), analysis of the relationship between the "01" section and its mention of "necessary medical services" and the definition contained in the "05" section requires a somewhat lengthy digression.

B. Federal Financial Participation in State Expenditures for Health Services Prior to the Enactment of Title XIX

Title XIX, enacted in 1965, created a separate system for providing medical assistance benefits to persons who previously received such benefits as a function of their eligibility for the more traditional form of public assistance: cash grants. For example, under title I (originally Old-Age Assistance (OAA)), federal financial participation was available to states in "an

amount, which shall be used exclusively as old-age assistance, equal to one-half of the total of sums expended. . . as old-age assistance under the State plan. . . ." 49 Stat. 621, § 3(a). This traditional cash grant form of public assistance was expanded in 1956 to include "medical assistance" and a medical "vendor payments" program. Although states had previously been able to assist OAA recipients in meeting medical expenses and obtain federal financial participation in the expenditures they incurred, they had been limited to providing this assistance as part of the monthly OAA cash grant, and rather low limits were placed on the maximum amount of a cash grant. As the Senate Finance Committee noted:

> The bill would provide Federal matching of expenditures for payments to suppliers [vendors] of medical care separate from money payments to assistance recipients and would use an average basis for determining Federal participation in payment to suppliers of medical care. . . . This assurance of Federal participation on an average basis should <u>stimulate</u> States to secure <u>necessary</u> care for recipients, particularly in States with relatively limited resources. . . . Under the bill all payments

> to suppliers of medical care would be matched under the separate provision. States would still be able if they chose to do so to include in money payments to recipients amounts to meet medical needs within the maximums on money payments specified in titles I, IV, X, and XIV [emphasis supplied].
> Sen. Rep. No. 2133, 84th Cong., 2nd Sess., July 26, 1956, reprinted in 3 U.S. Code Cong. & Admin. News 3877, 3905-06 (1956).

Two specific points are worth making at this juncture. First, the Congress, as it usually does when it improves the Social Security Act, expressed its intention in terms of "stimulating" — not requiring — the states to increase their expenditures for public assistance and recognized that, given the fiscal limitations of state governments, the most effective form of stimulation is increased federal financial participation. Second, this is the first time that the word "necessary" appears, as far as the amici states are aware, in conjunction with a discussion of medical care benefits. Significantly, the word does not appear in the 1956 amendments themselves.

Moving forward in time, the Social Security

Amendments of 1960 worked the penultimate significant change in Congress's approach to authorizing federal financial participation in state expenditures for medical care under their public assistance programs. Often referred to in part as the Kerr-Mills Act, portions of the 1960 Amendments were the predecessor of title XVIII (Medicare) and, as events unfolded, title XIX as well. Noting that "[t]he major issue presented to the [Senate Finance Committee] this year has been the increasing cost of adequate medical care for older people. . .," the Senate Finance Committee proposed substantial changes in the House bill, HR. 12580. For present purposes, the most significant change was to provide for the amendment of title I to include "medical services for the aged," and the most illuminating aspect of these amendments is the legislative history associated with the introduction of the phrase "necessary medical services." As a review of this material demonstrates, the lower federal courts and the Supreme Court of New Jersey in Monmouth have erred in reasoning that Congress used the phrase "necessary medical services" as an equivalent for the term "medically necessary" in title XIX. To the contrary, when it used the phrase "necessary medical services" for the first time in 1960, Congress had a completely different concept and purpose in mind.

The Senate Finance Committe's report accompanying the 1960 Amendments and referring specifically to the Kerr-Mills Act amendments to title I of the Act begins its analysis with the following instructive paragraph:

> Your committee has designed a Federal-State matching program based upon historic principles of Federal-State cooperation. This program is established under title I of the Social Security Act, thereby providing additional matching funds to the States to (1) establish a new or improve their existing medical care program for those on the old-age assistance roles, and (2) add a new program designed to furnish medical assistance to those needy elderly citizens who are not eligible for old-age assistance but who are financially unable to pay for the medical and hospital care needed to preserve their health and prolong their life. The twofold plan would thus cover all medically needy aged 65 or over, whether or not they are eligible for old-age assistance, or whether or not they are eligible for the benefits under the social security or any other

> retirement program. It accomplishes this objective within the framework of a Federal-State program with broad discrimination allowed to the States as to the programs they will institute, improve, and administer in meeting the health needs of the aged when illness occurs or continues [emphasis supplied].16/

Sen. Rep. No. 1856, 86th Cong. 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3608, 3610 (1960).

16/ The report contains a further and more explicit statement of purpose which is also worth reading:

> 1. Purpose
>
> The existing provisions of title I provide Federal funds to the States for medical services to aged individuals who are determined to be needy by the States. At the present time, States provide needy aged persons with "money payments" for medical

The report continues with a description of title I's

16/ continued

services and also provide "vendor payments" to the suppliers of medical care. . . . These provisions vary greatly. Some States have relatively adequate provisions for the medical care of needy persons; others have little or no provision. The increased Federal financial provisions in the bill are designed to encourage the States to extend comprehensive medical services to all needy persons receiving monthly assistance payments. Participation in the Federal-State program is completely optional with the States, with each State determining the extent and character of its own program, including the standards of eligibility and the nature and scope of benefits. The limits of Federal financial participation are discussed later in this report [emphasis supplied].

operation prior to amendment and the changes which the Committee intended to make in it. Although too lengthy to reproduce in their entirety here, certain sections deserve explicit mention. The report makes clear that Congress's intention was to "encourage," not require, the states to enlarge their expenditures for medical care services provided to persons receiving OAA or who, while able to meet the day to day expenses of life, are unable to incur susbtantial expenditures for medical services (the "medically needy"). While the Congressional goal was to encourage the development of "comprehensive medical care program[s]" for OAA recipients, the Senate Financial Committee deliberately wrote that, as to the scope of medical services the states might provide and still secure federal financial participation in their OAA expenditures, "[t]here is no Federal limitation on medical services provided under the bill. Each State may determine for itself the scope of medical services to be provided in its program." Similarly, as to the "medically needy" and the new Medical Assistance for the Aged (MAA) program, the Committee emphasized the incentive nature of its proposal and its intention that the states:

have broad latitude in determining eligibility for benefits under the program as well as the scope and nature of the services to be provided within the limitations prescribed. Thus, each State would determine the tests for eligibility and the medical services to be provided under the State program within the limitations described below. Federal financial participation would be governed by the establishment of an approved plan subject to the criteria and limitations prescribed in the law [emphasis supplied].

The limitations upon federal financial participation to which the Committee referred are listed in the immediately following section of the report which deals with eligibility:

> 2. Eligibility
> Benefits under a State program may be provided only for persons 65 years of age or over to the extent they are unable to pay the cost of their medical expenses. . . [emphasis supplied].

And then the Committee indicated exactly how it proposed to amend title I to accomplish its goals:

> Section 1 of the Social Security Act, as it would be amended by the bill, provides that one of the objectives of the title is to furnish medical assistance to individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services. . . [emphasis supplied].[17/]

Here, then, are the roots of the phrase "necessary medical services" which the lower federal courts and the court in Monmouth equate with the term "medically necessary." These roots rest not in the "02" plan requirements section of title I, but rather in the "01"

17/ The Conference Committee adopted the Senate Finance Committee's approach and its choice of the phrase "necessary medical services." Conf. Rep. No. 2165, 86th Cong, 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3749, 3756 (1960).

authorization section. They are nurtured not by a Congressional intention to require the States to provide any medical services at all, "medically necessary" or otherwise, but rather by a desire to limit the availability of MAA program benefits to those medically needy aged persons "whose income and resources are insufficient to meet the cost of necessary medical services [emphasis supplied]." Unless the Congress substantially altered its intentions between 1960 and 1965 concerning the federal-state public assistance programs and their medical services components which it created under the Act, the amici states submit that it should be clear that the phrase "necessary medical services," and the legal purposes it was intended to serve, are not equivalent — indeed, have nothing in common with — the term "medically necessary". The following discussion both brings this digression to a conclusion and demonstrates that the Congress made no such change in its intentions when it enacted title XIX.

C. The Enactment of Title XIX

Title XIX was enacted as a component of the Social Security Amendments of 1965, 79 Stat. 286. Title XVIII, which created the Medicare program, was the major provision of this set of amendments to the Act, and the

controversial nature of this initial national foray into health insurance overshadowed the issues involved in the drafting of title XIX. This result is understandable for, as the Congress conceived it, title XIX was simply a consolidation and improvement of the existing medical assistance programs already authorized under the Act's various categorical assistance titles. The Senate Finance Committee's Report makes this point clear:

6. BACKGROUND AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical

care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of needy aged, bline, disabled, and dependent children — the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs [i.e., "necessary medical services"]....

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish,

> effective January 1, 1966, a new title in the Social Security Act — "Title XIX: Grants to the States for Medical Assistance Programs." Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2014.[18/]

The Senate report then goes on at some length and in fair detail to describe the general nature of its proposals for title XIX and, in a section by section analysis, the effect of the proposal's specific provisions. See Sen. Rept. 404, 89th Cong., 1st Sess. (1965), reprinted in U.S. Code Cong. &

18/ The introductory summary of the proposed title XIX put the matter even more simply:

> In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to consolidate and expand the differing provisions for the needy which currently are found in five titles of the Social Security Act.

Admin. News, 2015-52 (1965). Three observations are worth making concerning the report's contents. First, it specifically discusses suggested state plan requirements for inclusion in the "02" section of the new title. Second, neither in its discussion of plan requirements nor anywhere else does the report mention the term "medically necessary" or suggest that the Senate Finance Committee intended to require the States to provide any specific type of medical services. Rather, as stated in the paragraphs dealing with eligibility and in reference to the "02" section requirements, the committee spoke only in terms of requiring states to include in their state plans "provision for medical assistance [to the categorically eligible and, if desired, the "medically needy"]," id. at 2017; see also 2144-45. Third, §1901 was taken, with appropriate adjustments to make its provisions applicable to all of the Act's categorical assistance titles, from §101, as amended by the Kerr-Mills Act in 1960. See id. at 2144.

And so, there it is. The relationship between "necessary medical services" and the defined term "medical assistance," the relationship which prompted this extended digression, now appears to be a straight-forward one. "Necessary medical services" is the phrase, inherited

from Kerr-Mills, which the Congress used first in Kerr-Mills and then in title XIX both to (1) expand the availability of federal financial participation beyond the categorically needy to the medically needy and (2) limit the federal obligation to participate in state expenditures to those incurred as "medical assistance" on behalf of persons "whose income and resources are insufficient to meet the costs of necessary medical services...[emphasis supplied]." "Medical assistance," defined as usual in the "05" section of the new title, imposes the substantive requirement through its use, as usual, in the "02" section. Neither phrase has anything to do with the concept to which the term "medically necessary" refers.

D. The Use of the Defined Term "Medical Assistance"

Observation of title XIX's architecture reasonably concludes with a moment's look at the detailing associated with the placement and use of the defined term "medical assistance." As it appears in the "05" section, the definition of "medical assistance" contains no mention of "medically necessary" health care services.

Indeed, it mentions no specific type of health care service or characteristic of a health care service. Rather, it refers to broad classes or categories of health care and services and defines "medical assistance" to mean "payment of all or part of the cost of the following care or services... [emphasis supplied]." This choice of form, as with most good modern architecture, is based upon a clear perception of function:[19/] to describe the type of state expenditure in which the federal government would be willing to participate while leaving to the states broad discretion to determine the exact nature of the benefits to provide eligible recipients.

E. Summary

Title XIX's structural lines have not changed significantly since Congress shaped them in 1965. While both

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19/ See generally L. Sullivan, The Tall Office Building Artistically Considered, Lippencott's Magazine (March, 1896) (containing the statement thought to guide modern architecture that "Form ever follows function").

Congress and the Department of Health, Education, and Welfare have made substantial additions to the basic structure over the past fourteen years, most noticeably in the areas of cost control and facility and service standards, the amici states have found no indication of an intention to alter the title's fundamental design principles, principles which rest upon the foundation which the Act erected in 1935: (1) a federal-state cooperative system of financial participation in state expenditures for public assistance which (2) recognizes the historic and primary role of the states in the social welfare area and (3) seeks to stimulate and encourage the improvement of state welfare programs by making federal financial participation available to states which (4) submit plans for public assistance programs to the Secretary of HEW which satisfy the Act's requirements. A well-designed statutory scheme such as this cannot reasonably be thought to have omitted from careful and explicit statement such an essential requirement as the Supreme Court of New Jersey in Monmouth and the lower federal courts in similiar cases have added to it.

CONCLUSION

The Court should grant the State of New Jersey's petition for certiorari in this case. Doing so would give it the opportunity to complete the examination of the issues which Town Court Nursing Home v. Beal, 586 F.2d 280 (3rd Cir. 1978), cert. granted sub nom. O'Bannon v. Town Court Nursing Center, Inc., 47 U.S.L.W. 3683 (April 6, 1979), has brought to its attention and to terminate a controversy which has adversely affected the administration of the national Medicaid program in areas as diverse as nursing home services and abortion surgery. It would also permit the Court to analyze the substantive issue of statutory interpretation, whether state plans for medical assistance must provide reimbursement for particular "medically necessary" services, in an environment free of the "unique" considerations, Bellotti v. Baird, U.S. , 61 L. Ed.2d 797, 818 (1979), associated with cases like Preterm and Zbaraz. Finally, this case offers an opportunity, perhaps more appropriate than that which Town Court presents, to establish once and for all the approach which the lower federal courts should use in evaluating claims of state obligation under title XIX of the Social Security Act.

For all of these reasons, then, the amici states urge the Court to accept this case for plenary consideration and issue a writ of certiorari to the Supreme Court of New Jersey to review its judgment in the case of Monmouth Medical Center v. State of New Jersey.

Respectfully submitted,

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APPENDIX A

COMPENDIUM OF RELATED CASES DECIDED UNDER TITLE XIX

I. CASES DISCUSSING WHETHER MEDICAID REQUIRES FUNDING OF MEDICALLY NECESSARY SERVICES.

A. Transsexual Cases

Doe v. State Department of Public Welfare
257 N.W.2d 816, 819 (Minn. 1977)

State of Minnesota denied Medicaid benefits to recipient for transsexual surgery. Court held state regulation violated federal law because it denied medically necessary services solely because of the diagnosis, type of illness or condition, in violation of 45 C.F.R. §249.10(5)(i). If operation medically necessary, funding could not be denied.

Pinneke v. Preisser
U.S. District Court (N.D. Iowa) No. C77-3023,
May 11, 1979

Challenge to Iowa's policy of denying Medicaid benefits for transsexual surgery. Court held that where operation is medically necessary, it is contrary to provisions of Title XIX to deny coverage under Medicaid; Title XIX requires states to provide certain services,

42 U.S.C. §1396a(a)(13)(B), and, within these categories, states have no discretion to deny coverage for medically necessary services.

Rush v. Parham,
440 F. Supp. 383 (N.D. Ga. 1977), app. pending sub nom. Rush v. Poythress, No. 77-2743 (5th Cir.)
argued September 29, 1979

Plaintiff, a Medicaid recipient, sought declaratory, injunctive and mandamus relief for improper denial of Medicaid reimbursement for transsexual surgery expenses. Court found operation medically necessary and held that benefits for medically necessary service are not the only Medicaid coverage which states may provide eligible recipients but they are the "irreducible minimum coverage which states must provide..."

B. Abortion Cases

D.R. v. Mitchell
456 F.Supp. 609 (D.Utah 1978)

Claim for injunctive and declaratory relief that Utah statute limiting abortion funding to those cases where life of mother endangered in conflict with Title XIX. Court held that Medicaid law does not require funding of all medically necessary abortions— discusses meaning of

"necessary medical services;" decides that Title XIX may not require the funding of any class of abortions, and, if it does require funding of some abortions, it requires the subsidizing of only those abortions lawful in most states when Title XIX was enacted. Summary judgment for defendants.

Doe v. Busbee
U.S. District Court (N.D. Ga.) No. C76-786A,
June 5, 1979

Georgia statute which limits funding of abortions to life-threatening situations and victims of rape or incest inconsistent with Title XIX which requires coverage for all medically necessary services within the mandated categories for categorically needy. Preliminary injunction entered enjoining state from refusing to provide reimbursement for medically necessary abortions for named plaintiffs.

Doe v. Kenley
584 F.2d 1362 (4th Cir. 1978)

State of Virginia wanted to eliminate Medicaid funding of non-therapeutic abortions; did so by requiring a physician to certify that mother's life would be endangered if abortion not performed, in order to obtain payment by state. District Court dismissed class action and Court of Appeals reversed and remanded,

saying policy could not be used to implement state's objective. Court did not reach statutory (Title XIX) or constitutional (equal protection; due process) issues; struck down on basis that policy is ambiguous — if aim is to stop payment for non-therapeutic abortions, payment for those which are life-threatening only, rather than health-threatening, not consistent with stated objective. Ambiguity violates §1396(a)(17) of Title XIX. Court's discussion implicitly accepts the premise that state must pay for medically necessary abortions.

Emma G. v. Edwards

434 F.Supp. 1048 (E.D.La. 1977), app. pending,
No. 79-1144 (5th Cir.)

Suit to enjoin Louisiana Health and Resources Administration from denying Medicaid payments for therapeutic abortions performed outside hospital and to enjoin State Board of Medical Examiners from enforcing state statute requiring all abortions to be performed in licensed hospital. Court accepted stipulation entered by the parties that state funded all medically necessary abortions and added that it would be required to do so under Maher and Beal.

Planned Parenthood Affiliates of Ohio v. Rhodes

C-2-79-687 (E.D. Ohio 1979)

Plaintiffs sought injunction against state officials barring implementation of Ohio statute which restricted state-funded abortions to those where life of mother endangered, or to pregnancies resulting from rape or incest, when certain reporting conditions are met. Court held that Title XIX requires funding of all medically necessary abortions; refused to accept the narrower holding of Preterm, Inc. v. Dukakis and other cases which find that the Hyde Amendment impliedly repeals Title XIX to require state funding of only those abortions for which federal funds have been appropriated by the Amendment. Injunction enetered barring state defendants from refusing to fund all medically necessary abortions for eligible Medicaid recipients.

Preterm, Inc. v. Dukakis

591 F.2d 121 (lst Cir. 1979)

On application for preliminary injunction, District Court had held that Massachusetts statute which prohibits payment for all abortions except those necessary to prevent death of mother unduly restrictive and in conflict with Title XIX; the purpose of Title XIX is to provide necessary medical services and medical service like abortion which physician deems "necessary" for a

Medicaid recipient must be publicly funded. 463 F.Supp. 222 (D.Mass. 1978). On appeal, First Circuit found that the language of Title XIX does not require funding of all medically necessary services, but that the restriction embodied in the Massachusetts statute nonetheless violated Title XIX because it is " 'unreasonable' and 'wholly [in] consistent with objectives of the Act,' 42 U.S.C. §1396a(a)(17), for a state to provide abortion services and then... deny it to all those who will not die without it."

Roe v. Casey

464 F.Supp. 487 (E.D. Pa. 1978)

Challenge to restriction contained in state statute prohibiting state funding of abortions except where necessary to save mother's life. Court held statute discriminated arbitrarily against medically necessary abortions on basis of diagnosis, type of illness or condition involved, in violation of Title XIX. Held that Title XIX requires participating states to provide all medically necessary services, including medically necessary abortions, to eligible recipients, and that plaintiff had a right to receive reimbursement under Title XIX for medically necessary procedures. Order entered granting permanent injunctive and declaratory relief.

Zbaraz v. Quern

596 F. 2d 196 (7th Cir. 1979)

Action to enjoin 1977 Illinois statute which withdrew state funding for all abortions except those necessary to preserve the life of the woman. District Court initially abstained, which order was reversed, 572 F.2d 582. District Court then held that Title XIX required funding of all medically necessary abortions. Court of Appeals held that Hyde Amendment amends Title XIX and limits what state must pay for under Medicaid. Essentially said that it agreed with 1st Circuit opinion in Preterm, Inc. v. Dukakis, that Title XIX does not require states to fund all medically necessary services, but found this limitation discriminatory on the basis of condition, in violation of 45 C.F.R. §449.10(a)(5)(i). Remanded with order to modify permanent injunction granted by District Court to order reimbursement for abortions fundable under the Hyde Amendment. On remand from Seventh Circuit, No. 77C-4522 (N.D.9111.), court held that Hyde Amendment violated 5th Amendment to Constitution.

C. Cases Involving Other Medical Services

Curtis v. Page

U.S. District Court (N.D. Fla.) No. TCA 78-732, April 18, 1979.

Challenge to Florida's limitation on physicians' services to three visits per month except in emergency, as in violation of Title XIX. Court enjoined state defendants from implementing state policy, holding that although Title XIX does not require that all medically necessary services be provided under a state plan, it does require that the state's decision as to what services will be covered be reasonable and consistent with the objectives of Title XIX. Florida's limitation not reasonable because:

(1) the coverage provided is not "sufficient in amount, duration, and scope to reasonably achieve" the purpose of Title XIX;

(2) the limitation is contrary to the requirement that services not be reduced or denied "solely because of the diagnosis, of illness, or condition"; and

(3) the limitation bases eligibility on the disorder from which the patient suffers by wholly denying payment for medically necessary services if the patient has three times previously made reimbursable visits to a physician.

Dist. of Columbia Podiatry Society v. Dist. of Columbia

407 F.Supp. 2159 (D.D.C. 1975)

District Court held that a fee schedule and limitation on scope of podiatry services which were reimbursable under Medicaid were reasonable limitations on scope of optional service — state can set level of benefits and is not required by §1396(a)(6) to pay for every service a podiatrist authorized to perform. Court emphasized that Medicaid funds are appropriated to enable each state "as far as practicable" under the conditions in such state to furnish Medical Assistance and services. Intent of Congress to give states considerable discretion. Defendants' motion for summary judgment allowed.

Dodson v. Parham

427 F.Supp. 97 (N.D.Ga. 1977)

Action to enjoin state's use of a drug list restricting number of drugs reimbursable by Medicaid. Preliminary injunction issued. Court held that although plaintiff recipients did not have property interest in continued receipt of particular drugs as a matter of due process, plaintiffs did have legitimate claim for entitlement to receive drugs sufficient to achieve purposes of Medicaid program, 45 C.F.R. §249.10(a)(5)(i). Relied on evidence of

physicians who testified that the list was inadequate on its face because it did not contain some drugs doctors felt necessary to treat certain conditions. Thus Court accepted reasoning that state must pay for medically necessary drugs, although did not analyze as a "medically necessary" case.

Virginia Hosp. Assoc. v. Kenley

427 F.Supp. 781 (E.D. Va. 1977)

Challenge to Virginia state plan provision limiting Medicaid reimbursement to 21 days in hospital. District Court held limitation reasonable and rationally related to state's legitimate interest in insuring fiscal solvency of Medicaid program; did not violate any provision of Medicaid statute or regulations including the regulation 45 C.F.R. §249.10(a)(5)(i) which requires that services under the state plan be sufficient to "reasonably achieve their purpose." In its analysis, court rejected argument that state must pay for all medically necessary services. Judgment for defendants.

White v. Beal

555 F.2d 1146 (3rd Cir. 1977)

Pennsylvania regulation limited expenditure for eyeglasses on basis of etiology rather than medical necessity; District Court enjoined as in conflict with

federal statute and Court of Appeals affirmed. Held state has to provide eyeglasses if medically necessary; cannot treat recipients differently depending on condition, 45 C.F.R. §249.10(a)(5)(i).

II. CASES DISCUSSING DUE PROCESS ENTITLEMENTS UNDER MEDICAID.

Bracco v. Lackner

462 F.Supp. 436 (N.D. Calif. 1978)

Plaintiffs, Medicaid residents residing in nursing home, sought injunction against decertification of home without prior due process hearing. Court held that Medicaid recipients had a right to a hearing prior to any action resulting in supervision, reduction, discontinuance or termination of assistance under 45 C.F.R. 205.10(a)(5), and decertification of a facility was within the scope of that regulation, relying on Klein v. Mathews.

Klein v. Califano

586 F.2d 250 (3d Cir. 1978), affirming Klein v. Mathews, 430 F.Supp. 1005 (D.N.J. 1977)

Court affirmed District Court's holding that HEW could not terminate payments to a decertified nursing home until it gave residents of the home a due process hearing on the issue of the validity of the

decertification finding. Court held that termination of federal financial participation to nursing home and the concomitant forced transfer of Medicaid residents to other nursing care facilities would deprive residents of interests protected by due process clause of Fifth Amendment. The right found is one to continued occupancy of a particular home, not merely, as HEW argued, to continued receipt of government assistance for care rendered by qualified providers. Court held that the source of this right was "the statutory provision permitting a recipient to obtain medical care from a freely selected provider and the regulations prescribing limited conditions for transferring a resident of a nursing home..."

Newfield House, Inc. v. Commonwealth of Massachusetts, et al.

U.S. District Court (D. Mass.) C.A. No. 76-3742-G

Plaintiff nursing home which refused to sign a provider agreement and voluntarily withdrew from the Medicaid program brought suit to require the state defendants to assume responsbility of transferring Medicaid recipients who were residents of the facility. Plaintiff named federal HEW official as defendant as well. Plaintiff's complaint also alleged that the

patients could not be transferred before they received notice and a hearing. In an opinion granting the federal defendant's motion to dismiss (March 28, 1979), the District Court held that no due process hearing was required in this case because it did not concern any "action taken by the federal defendants... which would be the subject of a hearing." State defendants' motion to dismiss or, in the alternative, for summary judgment, pending.

Roberson v. Wood

U.S. District Court (E.D. Ill.) Civ. No. 78-4321

January 18, 1979.

Plaintiffs, two residents of a nursing home, brought suit against administrator of home and Director of Illinois Department of Public Aid to enjoin planned transfers by the home to another facility. Plaintiffs alleged that transfers without hearing violated Title XIX. Court denied motions to dismiss by both private and state defendants and found in Title XIX a property right in plaintiffs to remain in home of their choice until they were given a due process hearing. Court applied Klein v. Califano reasoning although, in this case, nursing home administrator planned the transfer, not the state defendants.

Town Court Nursing Center, Inc. v. Beal
586 F.2d 280 (3d Cir. 1978), cert. granted sub. nom. O'Bannon v. Town Court Nursing Center, Inc., 47 U.S.L.W. 3683 (April 6, 1979)

Plaintiffs, Medicaid recipients and patients at a nursing home, had sought and obtained injunction against defendants' decertifying nursing home and transferring them before providing them with a due process hearing. Third Circuit relied on decision issued in Klein v. Califano on same day and remanded to District Court for a determination of what procedures would satisfy constitutional rights of recipients prior to decertification of home.